MONTANA LEGISLATIVE BRANCH

Legislative Fiscal Division

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Legislative Fiscal Analyst
CLAYTON SCHENCK

DATE: March 17, 2006

TO: Legislative Finance Committee

FROM: Lois Steinbeck LS
Marilyn Daumiller MD
Kris Wilkinson KBW

RE: Information Requests to Analyze DPHHS Appropriation Transfer

Legislative Fiscal Division staff has prepared and sent two memos to the Department of Public Health and Human Services (DPHHS) regarding the FY 2006 appropriation transfer request submitted by the Office of Budget and Program Planning. The most recent memo is attached for your review.

We plan to complete our analysis of most, if not all, issues related to the appropriation transfer for your review in early May. Please feel free to contact us if you have questions or notice issues that you would like us to pursue.

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Legislative Fiscal Analyst
CLAYTON SCHENCK

DATE: March 17, 2006

TO: Joan Miles, Director
John Chappuis, Deputy Director
Department of Public Health and Human Services

FROM: Lois Steinbeck
Marilyn Daumiller
Kris Wilkinson

RE: Information Needed to Evaluate Appropriation Transfer Request

Last week we sent you several questions related to the appropriation transfer request that the Legislative Fiscal Division (LFD) received from the Office of Budget and Program Planning (OBPP). Some of the questions were the same as those we had asked in mid February during preparation of the report to the Legislative Finance Committee (LFC) on the federal Deficit Reduction Act of 2006 (DRA).

In light of current department workloads, we appreciate how quickly department staff worked to answer the questions that we forwarded to you last week in time for LFC review. However, the information included in the response was insufficient to complete our analysis. Therefore we have follow up questions regarding the appropriation transfer and development of a plan to address ongoing shortfalls in FY 2007. Thank you for your attention to these questions.

The format of this document lists the original question that we asked, followed by the department response. Our follow up questions are listed after the department response.

Our plan is to complete the analysis of the appropriation transfer request by May 1. If some of the information that we have requested cannot be made available by April 7 to accommodate that time frame please indicate so in your response and let us know when the information will be available. Some of our questions are related to other cost saving measures that we may propose for LFC consideration. Finally, if you have questions about any of the information requests or process that the LFD intends to follow in analyzing agency appropriation transfers, please contact us.

Original question 1: The budget status report received from DPHHS on February 17 indicates a $6.1 million shortfall, possibly increasing to $7.1 million due to changes in the DRA. What occurred between February 17 and March 3 to increase the estimated FY 2006 shortfall by almost 100 percent?

Response: The budget status shortfall was $6.6m. This was increased by $3m due to the DRA, and $1.8m because of the uncertainties in the Medicaid estimates. We have been discussing the anomalies in the Medicaid expenditures this year. In particular, the removal of the inventory of claims when ACS implemented the optical reader system, which increased the number of payments going out the door; and there are more frequent and more expensive high cost claims this year. Both of these actions are skewing our mathematical projection results upward.

We originally estimated the impact of the DRA at $1m for FY06. This was the impact to CFSD. After further review, the impact may reach $3m department wide. As the budget status report was being finalized, the OPCA was consolidating the impact of the DRA and the proposed Bush budget. This impact review was initialized February 13 (copy attached), but was not finalized and distributed until February 21. We did send you a copy of the letter to the Governor around that time.

<<For brevity of this memo we note that a file showing the memo to the Governor and estimated costs of the DRA and the newly proposed budget by President Bush as included. A copy of this memo was also forwarded to the LFC and is posted on the LFD website.> >>

When we discussed these concerns with OBPP, it was felt it would be more prudent to estimate a worse case scenario now, and bring the estimates down later in the year, than it would be to be optimistic now and then have to increase the request at fiscal year end (and invoke an emergency in order to move adequate funds to close the year). This decision was made just late last week.

Follow up request: Please provide the documentation that supports the $5.9 million estimate for the impact to targeted case management included in the February 13 memo to the Governor. Also, please provide the definition of services that was used for the estimate in the February 13 memo and the impact by service area that supports the $5.9 million estimate.

During preparation of the LFD staff report on the DRA in late January/early February, we requested the documentation for the data that is included in that report and were unable to obtain it. While we received good data on the potential impact of the DRA from several programs in the department, we were unable to obtain information about impacts to the Addictive and Mental Disorders Division, the Senior and Long Term Care Division, and possibly others.

Original question 2: Why is the total amount requested $11.4 million when the DPHHS write-up accompanying the OBPP request notes a shortfall of only $9.6 million?

Response: The additional $1.8m is added because of the uncertainty in the Medicaid projections as discussed above.

Follow up request: Our confusion results from information in the memo supporting the OBPP appropriation transfer document. We interpreted the following bullet point (the third bullet on the first page of the memo) to mean that Medicaid costs could be as much as $8 million higher, not the $1.8 million. The bullet point in the memo states:

"Medicaid expenditures are exceeding budgeted authority, primarily in the Hospitals, Medicare Buy-in and Adult Mental Health Services categories, by $2.2 million. It is possible, though the DPHHS does not believe it to be likely, this amount could reach $8 million."

We asked for the assumptions or possible reasons that Medicaid could grow to $8 million over the appropriation rather than the $2.2 million projected due to that comment. Is that bullet point in error? If so, could you please provide a corrected memo?

Please provide the documentation or the rationale supporting the $1.8 million additional request for Medicaid costs or $8 million if the bullet point is not in error.

Original question 3: The OBPP request explains that the Medicaid shortfall may range from $2 to $4 million. The DPHHS narrative accompanying the request estimates a $2.2 million shortfall in Medicaid that could increase to $8 million in FY 2006. What is the documentation that supports the differences in these numbers?

Response: I suspect that the $8m referenced here is the overall department shortfall we were contemplating, not a shortfall in Medicaid only. The $6m original total department shortfall, plus $2m in the uncertainty factor is $8m.

Follow up response: This question is related to the previous issue and statement in the narrative accompanying the OBPP transfer request. Depending on the DPHHS response to the follow up for question 2, this question may be answered. If not, please address the original question asked.

Original question 4: LFD staff, working closely with DPHHS staff, prepared a report to show a preliminary estimate of the impacts due to the DRA. LFD staff cannot reconcile information provided by DPHHS as part of the DRA staff report with the amounts listed in the appropriation transfer narrative. What is the supporting documentation for the $3 million estimate for DRA in the transfer request?

Response: This is made up primarily of annual changes of $5.9m in TCM and $0.272 in Foster Care, divided by two for a January 1, 2006, implementation date. It should be noted that these are still very rough estimates as we have had no federal guidance in the implementation of these changes. Please see attachment in first question above.

Follow up request: Please note the LFD follow up question to the first question in this list. The department response to question 1 may answer question 4.

Original question 5: Why has DPHHS concentrated only on cuts to services and not other alternatives in its options to reduce costs?

Response: We needed to show items that would achieve reductions of the magnitude of the potential shortfall. We haven't had the opportunity to explore all possible actions, but will definitely consider all options.

Follow up request: Please provide other alternatives that you considered, whether or not those alternatives will be included in the final plan to address continuing shortfalls in FY 2007.

Original question 6: The legislature approved the DPHHS request to implement a Medicaid home and community based services (HCBS) waiver for adult mental health services. Waiver funding is sufficient to provide 105 service slots in the community and conceivably could reduce budget pressures at Montana State Hospital and in other adult mental health Medicaid services. DPPHS has had nearly a year since the legislature first approved funding for the waiver. Why is this proposal not discussed in the DPHHS narrative?

Response: The appropriation for the HCBS waiver for mentally ill individuals is not available until July 1, 2006. The Addictive and Mental Disorders Division is in the process of developing the waiver proposal. It is unknown if we will actually receive approval to provide these waiver services and, if approval is granted, it is our experience that start-up of such a waiver takes time. While our hope is that the waiver will be approved and that it will have an impact on both admissions and discharges related to Montana State Hospital, we do not see an immediate impact in this biennium.

Follow up request: We are aware that the appropriation for the AMDD HCBS waiver becomes effective July 1. DPHHS has had a year to prepare and submit the waiver proposal in order to implement the waiver July 1. The LFD staff concern is that the legislature approved the DPHHS request in February 2005 for the HCBS waiver and according to DPHHS testimony to the legislature at that time, the waiver would be up and running on July 1. Otherwise, the appropriation should have been scaled back to support the level of funding that was anticipated to have been expended in FY 2007 and information about annualizing start up costs in the 2009 biennium should have been provided to the legislature, especially since the match for this waiver is funded from tobacco tax revenue.

Please provide more program specific information on what has delayed the HCBS waiver, especially since additional staff resources have been added to deal with state hospital over crowding and program administration. Also, has DPHHS considered deploying more resources, specifically from the Senior and Long-Term Care Division, which manages an HCBS waiver, to assist AMDD in developing the waiver? Please provide the current timeline for potential waiver implementation and the annual impact that development of the waiver may have on state hospital populations and adult mental health Medicaid costs.

During the 2005 legislative session, DPHHS testified that the most significant service deficit in the adult mental health service system was the lack of community crisis services. Please provide information on what DPHHS is doing to address this deficit, including timelines for implementation of any proposed new crisis services, location of potential services, bed capacity of each service location, and the potential impact on the cost overruns at the state hospital and for adult mental health Medicaid services.

Finally, DPHHS and the Department of Corrections have been considering a joint treatment facility for state hospital forensic patients and for prisoners with a severe and disabling mental illness. Please list and summarize the options that have been considered, the resulting decision

for each of those options, and whether any of the options will be pursued. If any of the options will be pursued, please estimate the potential impact on the state hospital budget.

Original question 7: More aggressive outreach to identify and assist persons eligible for both the Mental Health Services Plan and Medicare could have reduced general fund costs since January 1. Persons eligible for both programs can receive their drugs through Medicare and receive premium assistance for Medicare drug plans through Big Sky Rx. What cost reductions could result if DPHHS pursued this option more aggressively?

Response: AMDD has aggressively pursued this option. Individuals eligible for MHSP are served by four Community Mental Health Centers. The CMHCs have been working for several months prior to January I, to identify their clients who are also Medicare -eligible, and to help those individuals choose a plan and complete the enrollment procedures. The Department has been trying for months to obtain information from the Social Security Administration about the individuals who are enrolled in Medicare. To date, that information has not been received and we are unable to update the state's MMIS to accurately reflect dual eligibility for this population. In order to be sure no person would be without medication and to respond to concerns by Senator Weinberg and others on the Interim Committee on Children, Families, Health and Human Services, the Department decided to allow individuals to remain eligible for the MHSP pharmacy program until May 5, 2006.

Follow up request: LFD staff have no concern with the DPHHS decision to continue MHSP services needed to help adults with a disabling mental illness manage their disease until they are enrolled in Part D. The concern is that the impact of Medicare Part D on the MHSP program could have been foreseen for at least a year and that action was not taken by DPHHS to request Medicare eligibility files from CMS until November 2005 – a time when CMS was buried in other duties and could not give the MHSP request a very high priority. Additionally, LFD staff raised the issue of why the MHSP program was not identified to CMS as a qualified state pharmacy assistance program during the summer of 2005 and that designation has only recently been made. The state hospital population issues began to emerge after planning for Part D impact to MHSP should have started.

Please identify specific actions being taken by AMDD and community mental health centers to identify and assist MHSP enrollees with Part D and Big Sky Rx enrollment. Has DPHHS considered requesting assistance from the staff in Senior and Long Term Care Division who are helping all Medicare eligible person to provide specific help for MSHP enrollees to apply for Part D and Big Sky Rx and if not, why?

Also what cost reductions are currently occurring due to MHSP enrollees moving into Medicare Part D and what could result if DPHHS pursued this option more aggressively?

Original question 8: Why hasn't DPHHS considered implementing co-payments for Medicaid services provided to higher income families as allowed by the DRA?

Response: In 2003 DPHHS implemented a thorough revision of copay under the Medicaid program. The current plan allows Montana Medicaid to operate a copay plan that is appropriate

for our state. We have copays for most services including drugs at the lower of $5 or 5%. Copay for prescription drugs is limited at a total copay of $25 per month per recipient. It should also be noted that eligibility in Montana is at or near federal minimums and the flexibility described in the DRA would not provide a lot of savings if any. Increases in copay for people at this low a level of income might put them in a position of being unable to pay the copay and therefore it is a hidden cost shift to providers.

Follow up request: The DRA makes changes to Medicaid co-payment limits and allows states to implement co-payments on children's services, which previously was not allowed in 2003 when DPHHS did its survey. The department response does not address the primary population that may have sufficient income and resources to pay higher co-payments while none are currently charged. The DRA allows states to charge co-payments for services to all persons on Medicaid, regardless of income and allows co-payments to rise as income rises.

Family income and resources ("family of one rule") are not considered in determining Medicaid eligibility for children's services in the developmental disability services system. The department administered a survey to families with children receiving Medicaid funded developmental disability services within the last two years. Answering survey questions was voluntary so the results were incomplete. However, responses to the survey indicated that some families had incomes in excess of eligibility limits for all programs administered by DPHHS and in some instances had incomes above 400% of the federal poverty level. Please provide information as to the ability of DPHHS to implement co-payments for families with incomes above the minimum federal eligibility limits for Medicaid and potential estimates of income and effect on service utilization.

The Children's Health Insurance Program (CHIP) requires families with incomes above 100 percent of the federal poverty limit to pay $215 annually toward CHIP coverage. It would seem that state and federal precedent exists in publicly funded health programs to require persons with incomes above the minimum Medicaid eligibility limits to contribute toward the cost of services. Please provide the department policy rationale for charging families who may have lower incomes a co-payment for state funded services while higher income families are exempt from co-payments for more extensive service coverage.

Original question 9: DPHHS should experience some cost savings as part of the DRA, including the asset transfer provisions and the revised method for calculating drug reimbursement. Are these general fund cost offsets included in the estimated shortfall?

Response: Savings related to the asset transfer change are down the road, and may be several months or years before they are realized. Other savings are anticipated, but we have been unable to calculate them. As noted above, we are still awaiting guidance from CMS regarding the implementation of the changes.

Follow up request: Since DPHHS has made estimates of shortfalls due to the DRA without adequate guidance from CMS, it seems appropriate that it also make some projections for potential savings. Please provide the best guess estimate of savings from each of the following provisions of the DRA by fiscal year for this biennium: 1) asset transfer look back provision; 2)

changes to the cost of drug reimbursements; and 3) co-payments of $100 annually for each family with a child eligible for Medicaid due to the "family of one" eligibility rule. If there are other cost-saving measures included in the DRA that we have not listed please identify and provide an estimate of those as well.

Original question 10: Why is the appropriation transfer in the Disability Services Division characterized as changes to policies at the Montana Developmental Center, when another contributing factor was the decision to implement higher provider rate increases than funded by the legislature?

Response: The 2005 Legislature funded a provider Medicaid rate increase in the Disability Services Division (DSD), Developmental Disabilities Program (DDP), with I-149 funds. The DDP also serves non-Medicaid DD clients, but the Legislature did not appropriate other funds to support a non-Medicaid provider rate increase. It is against Medicaid rules to set a Medicaid rate higher than a non-Medicaid rate. In order to stay in compliance with federal regulations it was necessary for DDP to raise both rates to the same level. DDP refinanced some general fund only programs and used the general fund to raise the non-Medicaid rate. This commitment of funding was implemented into DDP's standardized rates and into provider contracts prior to the beginning of SFY 2006. If DDP would have neglected to implement these rate increases, then DD providers would have not gotten any increase. This would have caused apprehension about the movement to a standardized rate system, which would further hamper the ability to close MDC unit 16AB, could put DDP in violation of the Travis D settlement and could lead to issues in DD community services that might jeopardize DDP's Medicaid waiver and ultimately Medicaid's participation in DDP community services.

Overtime projections for SFY 2006-2007 at MDC were a concern during the 2005 Session. DSD staff thought, at that time, that MDC could operate within the requested budget. Certain events occurred after the 2005 Legislative Session that affected the direct care staffing, and overtime budget, at MDC (such as the CMS interpretation of abuse including client-to-client abuse, commitment of certain individuals to MDC with extremely challenging behaviors, delays in closing unit 16AB due to a CMS moratorium placed on a DD community provider consisting of mainly near to total-care individuals, and increased need for MDC staff and clients traveling to community provider agencies for unit 16AB closure).

As these two situations are compared, the rate increase was a planned event funded with resources the department had, whereas the overtime deficit at MDC was an unplanned event due to external factors.

Follow up observations: DPHHS answered this question. However, we have the following observations. During session, LFD staff questioned the amount of the budget request for MDC overtime as being too low. LFD staff also questioned why the DD provider rate increases from I-149 requested by DPHHS were funded at the Medicaid matching rate. LFD staff is aware that some DD services are funded fully from the general fund and was surprised that the funding mix did not reflect that. LFD staff was assured during session that the funding within the DSD budget was adequate to support MDC overtime and the general fund portion of the rate increase

requested by DPHHS. The legislature appropriated the funds requested by DPHHS in good faith and did not knowingly short the department in either area.

It is important to note that the general fund cost of the provider rate increase for FY 2006 is $724,904 and for FY 2007 it is $752,179 – just about the amount of the projected shortfall for the Disability Services Division.

DPHHS has indicated that conditions at MDC are difficult. Staff training has been curtailed and other actions have been taken to reduce overtime costs at the institution. DPHHS staff has indicated that the actions taken may put institution staff at risk. LFD staff has a concern that actions taken may also jeopardize Medicaid funding for MDC services if the lack of staff training would in any way impact treatment programs or other services required to maintain certification. Medicaid reimbursements from MDC are deposited to the general fund as revenue.

LFD staff will identify options to reduce the cost of community services, which bears some of the responsibility for cost overruns. Options will be geared to reducing costs without reducing services or access to services at the community level with the goal of alleviating some of the stressful conditions at MDC and potential general fund revenue reductions.

New question 11: We have several questions about mental health service funding for children in foster care.

- Please provide the general fund cost for FY 2005 and an estimate for FY 2006 for mental health services provided to children in foster care who are not eligible for Medicaid funding of those services because the children do not meet the criteria for seriously emotionally disturbed.
- Does the Child and Family Services Division have a policy regarding how often children in foster care must receive a health screening as required by the federal Medicaid regulations associated with the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) provisions? If so, what is the policy and please provide documentation as to whether the policy is followed and how many children in foster care received an EPSDT screen in FY 2005 compared to the total number of children in foster care?

New question 13: Please provide a preliminary projection of the clawback payments due the federal government and estimate when the payments will be made.

New question 14: We have several questions regarding the Health Insurance Flexibility and Accountability (HIFA) waiver.

- What is the current time line projected for submission of the HIFA waiver to the Governor and, if approved by him, to the Centers for Medicare and Medicaid Services (CMS)?
- Since DPHHS staff has worked closely with top officials of CMS on this waiver, when would it likely be approved and when would the waiver be implemented, if the Governor forwards the waiver to CMS?
- Could DPHHS use the additional funds for mental health services that would be generated by the HIFA waiver to offset supplemental costs in FY 2007?

New question 15: It is LFD staff's understanding that children eligible for services under the "family of one rule" are eligible for all Medicaid services. Is that accurate? If so, would Medicaid regulations allow the state to define a more limited benefit package of basic Medicaid services for children eligible under the "family of one rule" and still allow those children to receive other specialized, targeted services?

New question 16: Please provide the average per client cost for targeted case management services by adult and child for the following service systems for FY 2005 and an estimate for FY 2006: mental health, senior and long-term care, and disability services.

New question 17: Please provide a plan that lists each specific step that DPHHS will take to mitigate the FY 2007 shortfall in compliance with 17-7-301(1), MCA. While the list of options provided in the memo accompanying the appropriation transfer request details significant steps that could be taken, we are unsure what actions to analyze as part of the appropriation transfer request.

cc: Scott Sim, Chief
Budget Unit Bureau, Director's Office
Department of Public Health and Human Services

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OFFICE OF THE GOVERNOR
BUDGET AND PROGRAM PLANNING
STATE OF MONTANA

BRIAN SCHWEITZER
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PO BOX 200802
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TO: Clayton Schenck, Legislative Fiscal Analyst
Legislative Fiscal Division

FROM: David Ewer, Budget Director
Office of Budget and Program Planning

DATE: March 2, 2006

SUBJECT: **LFC Review and Comment on a Fiscal Year Transfer Supplemental Appropriation**

In accordance with Title 17, Chapter 7, part 3, MCA, the Governor's Office of Budget and Program Planning is submitting for review and comment at the March meeting of the Legislative Finance Committee a proposed supplemental appropriations to transfer FY 2007 authority to FY 2006.

- The Department of Public Health and Human Services has requested a transfer of up to $11.4 million general fund from FY 2007 to FY 2006. The largest driver of the request: Costs associated with the overcrowding at the Montana State Hospital $3.7 million ; 2) Impact of the Federal Deficit Reduction Act - $3 million; 3) Medicaid expenditures exceeding budget authority - $2 to $4 million; and 4) Administrative leave costs at the Montana Developmental Center - $.7 million. These costs are anticipated to replicate in FY 2007 and will be increased by an additional $3 million due to a full year impact of the Deficit Reduction Act and $6 million due to a decrease in the Federal Medical Assistance Participation (FMAP) for FY 2007 which is the federal share for the cost of Medicaid. Attached is a more detailed breakdown of the transfer amount as well as a memo outlining the steps the department will take to mitigate the effects of the supplemental in FY 2007.

Please let us know if you wish additional information on this transaction.

C: Joan Miles
John Chappuis
Taryn Purdy

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The Department of Public Health and Human Services estimated general fund appropriation shortfall is due primarily to unavoidable expenditures exceeding appropriations in the following areas:

- The Montana State Hospital opened the receiving unit to alleviate overcrowding. There were significant health and safety issues, which required this action. When the unit was opened, the facility added 36.60 FTE, who were not included in the budget. We also experienced a very high staff turnover rate that required unbudgeted pay exceptions in order to retain staff. The cost overrun at MSH is estimated to be $3.7 million.
- The Montana Developmental Center is estimating a cost overrun of $0.7 million. This is due primarily to overtime expenditures that are being incurred to cover staff on administrative leave. Federal regulations changed in 2005, which require the facility to place on administrative leave staff who make any kind of physical contact with residents of the facility while an investigation is made regarding the contact.
- Medicaid expenditures are exceeding budgeted authority, primarily in the Hospitals, Medicare Buy-in and Adult Mental Health Services categories, by $2.2 million. It is possible, though the DPHHS does not believe it to be likely, this amount could reach $8 million.
- The Federal Budget Deficit Reduction Act (DRA), which was recently passed, could increase general fund expenditures by $3 million in FY06. DPHHS is awaiting federal interpretation and regulation changes regarding the DRA.

There are additional potential pressures on the general fund that are not included in the request to move appropriations as the impact will not be realized until FY 2007.

- A full year of impact from the DRA will increase general fund expenditures by $6 million.
- The proposed presidential budget for FY07, if it were passed as is currently written, would require increased general fund expenditures of another $18 million in FY07 in order to maintain current service levels.
- Finally, the federal Financial Medical Assistance Participation (FMAP) rate for FY07 is less than the amount anticipated when the budget was established. This new rate will result in an additional $6 million general fund shortfall in FY07.

The following potential actions are forwarded as required in MCA 17-7-301 (7) (b) that could be considered to assure the department reduces, to the greatest extent possible, the expenditures in excess of appropriations or funding for the 2007 biennium. The amounts shown are all annual savings that could be generated with an implementation date of July 1, 2006. This is the earliest the department could implement programmatic adjustments that require administrative rule changes. SB-478 of the 2005 Legislature eliminated the state's ability to implement emergency rules in order to achieve a budget reduction in a more expeditious manner.

The department's review will be governed by the principles established SB-41 (listed below for reference) for the Montana Medicaid program and will focus on ensuring that access to services is not impacted for Montanans in need of departmental funded services:

- Protecting those persons who are most vulnerable and most in need, as defined by

a combination of economic, social, and medical circumstances;
- Giving preference to the elimination or restoration of an entire Medicaid program or service, rather than sacrifice or augment the quality of care for several programs or services through dilution of funding; and
- Giving priority to services that employ the science of prevention to reduce disability and illness, services that treat life-threatening conditions, and services that support independent or assisted living, including pain management, to reduce the need for acute inpatient or residential care.

The following roster of potential areas to be reviewed for reduction includes several unpalatable items. They demonstrate the magnitude of available appropriations that could be made available if these cuts were made in whole or in part in order to contribute to eliminating deficit for the 2007 biennium.

- Eliminate the Mental Health Services Plan Drugs – potential savings of $2,949,129.
- Eliminate Drugs as an optional Medicaid service – potential savings of $8,718,297.
- Provider Rate reductions – an across-the-board reduction of 7.9% in Medicaid provider reimbursement would generate potential savings of $16,000,000.
- Eliminate all optional services under the Medically Needy program – potential savings of $8,219,390.
- Eliminate all optional adult Medicaid services, including drugs, waiver services and optional services for medically needy – potential savings of $37,408,123.
- Remove the additional 36.60 FTE that were recently added to MSH – potential savings of $1,453,324.
- Eliminate remaining general fund only services (e.g., DD, Mental Health Services Plan) – potential savings not identified.
- DPHHS is continuing to lower administrative costs (i.e., restrict travel, postpone filling positions, etc.)

There are some obvious disadvantages to implementing reductions in many of these areas. These include:

- Eliminate the Mental Health Services Plan Drugs – A significant cost shift would be expected if drug coverage were eliminated. Without drugs, individuals' health would deteriorate to the extent that more intensive services would be required, such as in-patient hospital and nursing home services.
- Eliminate Drugs as an optional Medicaid service – Similar to MHSP drugs, a significant cost shift would be expected if drug coverage were eliminated. Without drugs, individuals' health would deteriorate to the extent that more intensive services would be required, such as in-patient hospital and nursing home services.
- Provider Rate reductions – Provider rate reductions could have a negative impact upon access to service, as some providers may no longer accept Medicaid clients. When the general fund savings are matched with federal Medicaid dollars, the total reduction is approximately $52 million.
- Eliminate all optional services under the Medically Needy program – Similar to the elimination of the drugs programs, a significant cost shift would be expected if

coverage were eliminated. Without care, individuals' health would deteriorate to the extent that more intensive services would be required, such as in-patient hospital and nursing home services. When the general fund savings are matched with federal Medicaid dollars, the total reduction is approximately $26.6 million.

- Eliminate all optional adult Medicaid services, including drugs, waiver services and optional services for medically needy – Similar to the elimination of the drugs programs, a significant cost shift would be expected if coverage were eliminated. Without care, individuals' health would deteriorate to the extent that more intensive services would be required, such as in-patient hospital and nursing home services. When the general fund savings are matched with federal Medicaid dollars, the total reduction is approximately $121.1 million.
- Remove the additional 36.60 FTE that were recently added to MSH – The safety and security issues that these additional staff here intended to resolve would likely recur.
- Eliminate remaining general fund only services (e.g., DD, Mental Health Services Plan) – A cost shift to much more expensive care in the state's institutions would result.
- DPHHS is continuing to lower administrative costs (i.e., restrict travel, postpone filling positions, etc.)

Unfortunately, in spite of DPHHS' current efforts, the fiscal outlook for 2006 worsens significantly in FY 2007. The state will feel additional impact of reduced federal funding resulting from the DRA and from a smaller federal percentage in the cost of Medicaid. The trend to move a larger share of healthcare and social services costs to the states continues, as demonstrated in the proposed President's budget for FY07.

DPHHS is exploring all viable options to control the effects of decreasing federal dollars. The department is examining provider rates; continuing efforts to lower administrative costs (i.e., restrict travel, postpone filling FTE positions, etc.); and examining all programs for cost reduction opportunities.

It is DPHHS' expectation that a supplemental appropriation request in FY 2007 is unavoidable in order to fulfill current program obligations in an environment of continuing reduced federal funding. The department believes that a supplemental appropriation request in FY2007 is unavoidable unless the programmatic actions addressed above or similarly onerous program reductions are made.

The actions listed above, such as elimination of optional services in the Medically Needy program or all optional adult Medicaid Services, necessary to reduce expenditures would have a lasting and negative impact to many Montanans. The Department does not make these suggestions lightly and does not consider them to be in the best interest of the state.